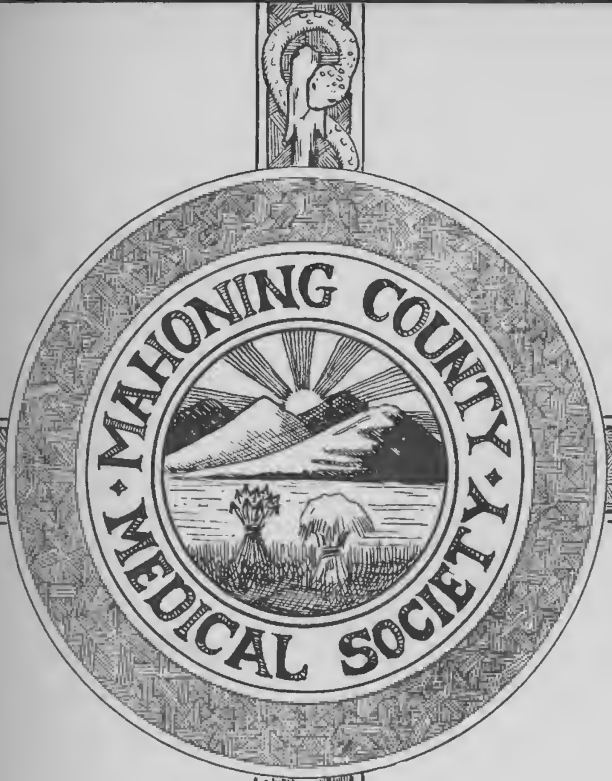

"Courage is the thing. All goes if courage goes."
—J. M. BARRIE.

BULLETIN

of the

Mahoning County Medical Society

Vol. X No. 10
October 1940

BULLETIN
THE MAHONING COUNTY MEDICAL SOCIETY

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Vol. X—No. 10

CONTENTS

October, 1940

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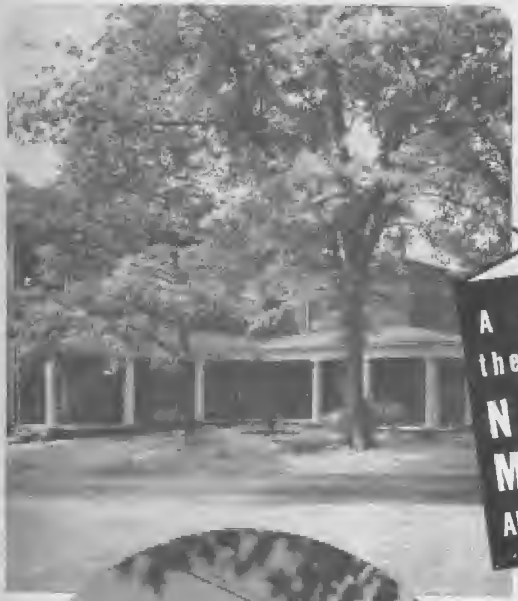

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PRESIDENT'S PAGE

Proximity to the possible advent of war forces us to turn our attention in that direction.

Being on the alert, the Ohio State Medical Association has appointed a Medical Preparedness Committee to function in setting up proper arrangements in advance of federal and state demands of the recent Conscription Act. In turn, the County medical societies have been requested to appoint a Sub-Committee to the Medical Preparedness Committee of the state association. This has been done in Mahoning County and the committee is already functioning according to requests of the state group.

Thus preparation for war is a stern reality. The medical profession is at all times ready and willing to do its part in defense of our country. It is a historic fact that doctors have always been in the center of the stage, whether fighting disease in times of peace or caring for the casualties of war. They go to the front, they work in base hospitals, they aid in preparation at camps, they care for those who remain at home. In all categories they are highly essential.

Those who fight disease at home are not always the safest, as was so forcibly demonstrated in the influenza epidemic of 1918. Many doctors even today are paying the toll of the strain and overwork endured at that time.

It is estimated by Dr. Charles C. Hillman, Colonel, Medical Corps, U. S. Army, that in case of a major mobilization we shall require 15,000 to 40,000 commissioned officers in the Medical Department alone. The first effort of the newly mobilized medical officer will be directed to the physical examination of recruits and of registrants under the selective service act. Dr. Hillman says that a superior army cannot be molded from inferior individuals and morons, but that the first call will be for the best of our young men, for those who can withstand the mental as well as the physical strains of war and who have the intelligence to perform any of the multitudinous and hazardous tasks that may befall the soldier in the field and during combat. It will be the task of the examining physicians to choose these men.

R. B. POLING, M. D., President.

BULLETIN *of the* Mahoning County Medical Society

OCTOBER 1940

Editorial---

THE BULLETIN— AND HOW COME!

Our *Bulletin* is the property of each member of the Mahoning County Medical Society, in his individual capacity as a member. It should, therefore, not be used for any purpose other than fair and square and equal service to each and every member, and it never is. Personal opinions may be, and often are, properly, given space in the discussion of mooted questions, but equal opportunity to express dissent from any such is a consequent right, and is in practice so recognized. Two conditions only must be observed: First, a controversial subject must bear some special interest to doctors; and second, the material must be strictly on the subject, concise and as short as possible, and in good taste.

The *Bulletin* soon will complete its 10th volume. The policies so clearly thought out at the beginning remain unchanged, and are adhered to with undeviating fidelity. This fact, plus its unquestionable usefulness to the Society, accounts for its vitality and the constant interest in it of those who have followed it for a long time.

Whether you read the *Bulletin* or not is your business. But if you do not read it you miss a great many interesting and worth while things. That is a fact, not boosting or boasting palaver. That fact has the confirmation of too many well-informed members of our own Society, and of others of the Profession, as well as of discriminating lay readers, to leave any doubt about it. For this the present Editor claims no personal credit, nor do any of his predecessors. It is simply the natural result of the efforts of MANY, along with the inherently special interest of the subject matter to us for whom it was prepared.

One thing justifies very great emphasis. The *Bulletin has never cost you nor the Society one red cent.* No part of your dues is used for the *Bulletin;* not only do we get it without the outlay of one thin dime, but we send it far and wide, to hundreds of our neighbors and friends—also without cost to them.

Nobody makes this possible except our *advertisers.*

Now the Big Point is this: what do we—you as an individual—I as an individual—owe to those advertisers who do this big thing for us? They not only give us pleasure, they not only inform us with their elegantly worded advertisements—they do what is more important: they *promote the progress of medicine and our Society.* And they do this in a *big way.*

You may not care about the church—at least a few say they don't: but you know very well what a hell-of-a-hole this community would be without our churches. So, also, you may not care about the *Bulletin:* but without it you very well know that our Society, the hand-maid of good medicine and decent medical practice, would be terribly crippled if the *Bulletin* should fold up.

The answer is easy: help those who have helped us. One strong proof of the worthiness of our friend is that he is our friend!

DR. HARRY E. WELCH

"O give us men!" each barren age has cried
To voice its emptiness; for they are few
Who through the common paths of life pursue
A course that in the end has dignified
The lowly ways of men. Now one has died.
How rich his life had grown, full well we knew
Who shared his faith in what is fair and true:
For while he searched for what might still abide
Amid the wreckage time and men had wrought,
He kept a faith and found enduring strength
When fashion's fallacies, which long had stood,
Were gone. Here honor was, and kindly thought,
And worthy men who knew him grew at length
To know that what they found in him was good.

—Warren Deweese Coy, M. D.

DR. COLE LIKED US

He writes: "I don't know when I have gone to a meeting of this sort when I have felt so much at home, and where the hospitality was so evident, and where I enjoyed myself so much. Of course, I saw a lot of men I had not seen for a good many years, and it was a pleasure to renew old acquaintances. Moreover, you have a fine group of medical men in Youngstown, and it was a pleasure to be with them. You may have noticed that I enjoyed my dinner to the fullest extent. The whole evening was very pleasant, and I want to thank you for seeing to it that I was invited down there."

(And we liked you, too, Dr. Cole!)

THE GIRLS ORGANIZE

An Auxiliary of the Mahoning County Medical Society was organized and officers were elected when approximately 100 doctors' wives met in Room 206 at the Y. M. C. A., Wednesday afternoon, September 25.

Dr. R. B. Poling, President of the Society, spoke briefly of the need for such an organization, and introduced Mrs. J. E. Purdy of Canton, Ohio, president of the State Auxiliary, who talked enthusiastically about "Aims and Objectives." Mrs. Purdy has long been active in the Stark County Auxiliary, which has been functioning for twelve years and has been of much service to that community.

Ballots were distributed, and the members voted for some one for a nominating committee. The five women having the greatest number of votes and, therefore elected were: Mrs. Walter King Stewart, Mrs. R. B. Poling, Mrs. Orrin W. Haulman, Mrs. L. G. Coe, and Mrs. Claude B. Norris.

This committee presented the following list for officers (unanimously elected): Mrs. R. M. Morrison, President; Mrs. C. D. Hauser, President-Elect; Mrs. John D. Heberding, Vice President; Mrs. John Noll, Secretary, and Mrs. John McDonough, Treasurer. No floor nominations were made.

Mrs. Morrison named Mrs. Walter King Stewart, Mrs. Claude B. Norris and Mrs. L. G. Coe as a committee to draw up and submit a Constitution and By-Laws at the next meeting, early in October. At that time, also, a program of activities will be arranged. The Auxiliary is extremely anxious to understand fully the problems of organized medicine and to coöperate with the Mahoning County Medical Society.

Important New Committees

Advisory Committee to the Woman's Auxiliary to Mahoning County Medical Society

Dr. A. J. Brandt, Chairman; Dr. James Birch, Dr. W. K. Stewart, Dr. John McDonough, Dr. C. D. Hauser, Dr. Walter B. Turner, Dr. A. M. Rosenblum, Dr. O. J. Walker.

Committee on Medical Preparedness to the Mahoning County Medical Society

Dr. F. W. McNamara, Chairman; Dr. Ralph Morrall, Dr. L. G. Coe, Dr. James Herald, Dr. A. E. Brant, Dr. Charles H. Warnock.

THE USE OF THE DOUBLE LUMEN INTESTINAL TUBE IN SMALL INTESTINAL OBSTRUCTION

By WALTER B. WEBB, M. D.

(This is the third of four papers presented by our hospital interns before the Mahoning County Medical Society. Dr. Webb is from the Youngstown Hospital Association.)

History: Gastric and duodenal suction have been used during the past 20 years in the treatment of small intestinal obstruction. Wangensteen in 1933 increased the effectiveness of this method by introducing the continuous suction—siphonage apparatus connected to the Levine gastro-duodenal tube. In 1934 Miller and Abbott while endeavoring to obtain kymographic records from an inflated balloon in the duodenum, found their efforts repeatedly frustrated by the rapid passage of the balloon into the jejunum. They conceived the idea of attaching a second larger tube to the small tube with the balloon. This second large tube was attached to a continuous suction and as the balloon was carried progressively through the duodenum, jejunum and ileum by the peristalic waves of the intestine, the material in each successive portion was aspirated. This method while first used only experimentally to determine the motor and secretory activity of the small bowel has now come to be used in the treatment of all types of small intestinal obstruction.

Use: In 1938 Abbott reported 16 cases of intestinal obstruction in which intubation had been tried with favorable results.

The field of usefulness is limited to obstruction of the small bowel. It has been repeatedly shown that distension in the large bowel is very rarely relieved by intubation.

The tube has been used successfully in *mechanical obstruction* such as due to adhesive bands, annular carcinomas, post-operative edema, and in *paralytic* ileus such as is found following fractures, pneumonia, passage of ureteral and gall bladder calculi, post-operative and post-partum conditions and accompanying general peritonitis.

It has been shown that peristalsis is first rendered more effective and then abolished by progressive distension and that in the presence of obstruction a zone of absent peristalsis, preceded by a zone of hyperperistalsis extends progressively around from the point of blockage. Until death of the muscularis this process is reversible. Thus even a patient who has had an obstruction for a long time and who presents great distension of the abdomen with no audible peristalsis or one who has shown a paralytic ileus from the start may undergo intubation successfully because as the stomach, duodenum and subsequent sections of the small bowel are deflated each in turn regains its peristaltic activity and forces the balloon onward.

Technic: The technic of passing the tube is to fold the balloon umbrella fashion, lubricate it with glycerin or some similar lubricant, and pass it through the nostril into the nasopharynx. In some cases it may be necessary to pass the tube through the nostril and out the mouth before attaching the balloon. The patient then drinks water as the tube is swallowed. The tube is inserted to the length of about 45 cm. and left in place. At this point the tip of the tube is just inside the cardia of the stomach. The patient is then placed on his right side to facilitate the tube gravitating to the pylorus. It is not taped to the patient but allowed to remain free and the patient is instructed to push the tube in a few cm. at a time until it reaches the 75 cm. mark. The patient is urged to drink a few sips of water every 15-20 minutes as this aids in keeping the tube free from the

(Continued on Page 302)

INTRACRANIAL HEMORRHAGE

By P. G. HODGIN, M. D.
(This is the fourth and last of the interns' papers. Dr. Hodgin is from St. Elizabeth's Hospital.)

From the beginning of time man has been stunned, if not killed outright, by blows on the head. The causative factors then were the war club, battle ax—probably Eve's primitive rolling pin, and little David's sling shot. Today, slippery floors and sidewalks and the automobile manage to hold their own. Even then, much was learned about the treatment of head injuries which is still regarded as correct therapy today. The Hippocratic principle was to relieve any excessive tension that might be present within the skull. This was done by looseninf the cranial shell, making more room for the brain and for the extravasated blood. They trephined the skull but did not open the dura. Experience had shown that if the dura were opened and a way made from the brain to the surface of the scalp, a softened, protruding and ultimately fatal tumor resulted—which today is known as a fungus cerebri. This is about as far as intracranial surgery had advanced up until the comparatively recent advent of antisepsis and asepsis.

The late J. B. Murphy, in discussing head injuries, said that no head injury is so trivial but that the patient might die, nor any head injury so serious but that the patient might recover.

Now to emphasize a few fundamental anatomical and physiological mechanisms pertinent to head injuries: We have given a nonresistible cranium, inside of which are the brain, arterial and venous blood, and the cerebrospinal fluid, all of them incompressible. In the case of an increase of cranial contents, due to edema or hemorrhage, something has to give. Accommodation of the brain is favored by the outflow of cerebrospinal fluid and venous blood; and if the edema is not marked, compensation occurs in this way. If greater swelling occurs, the intracranial pressure rises above the venous pressure and collapses the cerebral veins. Congestion of the brain occurs, because even though the veins are collapsed, arterial blood is still pouring in—similar to a leg in a tight cast. Then follows more swelling which raises the intracranial pressure above the arterial pressure and shuts off the inflow of blood to the brain causing anemia of the vital medullary centers, which, if not taken care of properly, results in death. However, the medullary centers are physiologically influenced by the intracranial pressure so that the blood pressure rises above the intracranial pressure for a while then is overwhelmed, only to compensate again. This mechanism is limited and sooner or later, compensation breaks. Then follows a drop in blood pressure. The pulse, previously slow, full, and bounding, speeds up and becomes thready and weak. Respiration, heretofore stertorous and loud, becomes Cheynne-Stokes in character and stops several minutes before the heart beat does. The temperature goes up and normally fluctuates 2 to 3 degrees, but in case of a failure of compensation, the heat regulatory center on the floor of the third ventricle is so overwhelmed by the increased intracranial pressure that all control is lost, giving rise to a hyperthermia of 106 to 108 degrees. Strangely enough, the patient hardly ever perspires—is hot and dry. This is probably due to a similar paralysis of the autonomic center controlling the sudariferous glands.

Now for a practical application of these fundamentals to intracranial hemorrhage. The most common classification of intracranial hemorrhage is anatomical, depending upon whether or not the hemorrhage

(Continued on Page 307)

The Use of Double Lumen Intestinal Tube in Small Intestinal Obstruction

(Continued from Page 300)

sides of the stomach where it tends to stick to the mucous. Also the tube is connected immediately to the continuous suction. About every 30 minutes the tube is irrigated with an ounce or two of soda bicarbonate solution in order to keep it open and make certain that the suction tip does not become clogged. The time taken for passage into the duodenum varies greatly but is usually between 2 and 24 hours. There are several methods used to test when the tube is in the duodenum. Often the material from the stomach will be clear fluid while that from the duodenum may be almost pure yellow bile. On injecting air into the balloon with a syringe while the tube is in the stomach the plunger is ejected rapidly in on continuous motion while after it has passed into the duodenum, the return of the syringe is often delayed and then is ejected with a series of strong rhythmic contractions. Also, if it is in the duodenum as soon as the balloon is inflated there may be a tugging on the tube as the peristalic waves carry it forward.

In some, where the stomach lies on either side of a prominent spinal column—saddle fashion, a partly inflated balloon will float the tube across the midline to the pylorus.

In about 50% of the series reported both by Abbott and Johnston, the intubation was successful without the aid of fluoroscopy.

Even when there is some delay in passing the tube into the duodenum the Miller-Abbott tube is exerting continuous suction and accomplishing just as much as ordinary gastric continuous suction. When however, after a trial period without having the tube pass into the duodenum, fluoroscopy may be necessary. Leigh, Nelson, and Swenson in their article on a series of cases from Presbyterian Hospital in New York state "the benefits to be derived from early intubation far outweigh any temporary discomfort caused a sick patient by transportation to the fluoroscopy room."

The usual fluoroscopic procedure is an attempt to manually guide the tip of the tube into the duodenum. The above authors also suggest that when manual attempts are unsuccessful the tube may be placed with a loop along the greater curvature of the stomach. The tube is fixed in place with flamed adhesive tape across the upper lip and the patient returned to his room. This is to prevent the tube from being pushed backward rather than forward. The continuous suction and periodic lavage are continued. The tip of the tube can only move forward a distance equal to the unkinked loop in the stomach and as the stomach regains tone by deflation the antral systoles carry the tip into the duodenum.

Another procedure has been suggested. The stomach is inflated with air under fluoroscopy then rapidly deflated and the deep peristaltic waves stimulated carry the tip into the duodenum. When the tube has been demonstrated to be in the duodenum about 20 cc. is placed in the balloon until it has passed the ligament of Trietz as a larger amount may hinder its progress there. Later about 40-50 cc. is put in the balloon, the continuous suction and periodic lavage continued.

Often the fluid content of an obstructed loop is too thick for the continuous suction to evacuate without dilution by lavage. The patient is instructed to push in an additional six inches of tube every one or two hours, or whenever the tube is felt tugging against his nose as it attempts to advance. If the tube buckles in the patient's throat it usually means that there is sufficient in the stomach and forcing more down will cause it to coil in the stomach.

In the Presbyterian series of 70

Abram Everett Frye, M. D.

Born December 17, 1870—Died September 3, 1940

We chronicle in sadness the passing of an honored member of our Society who for long fidelity to the ideals of medicine enjoyed the affection of us all.

Thirty-eight years ago, in 1902, Dr. Abram Everett Frye, a farm boy from Charleroi, Pennsylvania, where he was born on December 17th, 1870, was graduated at the old Chicago Medical School, into medicine. That was in the early part of what may well be termed the "Ultra-Scientific Phase" of medicine. It was a little later that thinkers were able to restore the "Art Phase," and give union to these two concepts in the highly efficient forms of medical service of today. Dr. Frye belonged to this rationalizing group.

After a course in Physio-therapy in 1903, Dr. Frye began practice at Marion, Ohio, in 1904. Soon after, he went to Raymond, Ohio, but in 1906 he came to Youngstown, where he served faithfully until September 3rd, 1940, when death closed his career.

He leaves his wife, the former Cherrie Hubbs, daughter of Dr. J. Allan Hubbs of Charleroi, and one son J. Allan, who resides at the parental home, 1912 Hillman Street.

The Society extends sympathy to the family of this servant of the suffering and lover of good books and medicine.

(We regret our inability to obtain a photograph of the late Dr. Frye.)

cases intubation was successful in 68 cases. Five of the failures occurred in the first 10 cases. Johnston in 500 cases had only 6 where intubation was unsuccessful.

When the tube no longer advances yet is still open and functioning well it may be assumed that it has reached the point of obstruction. Abbott & Johnston demonstrated that the tube advances to within 1 to 3 inches of the point of obstruction. At this time 50 or 100 cc. of dilute barium can be injected to visualize the obstruction. This procedure is safe because after observation under fluoroscopy and x-ray the barium can be aspirated back through the tube. This allows x-ray diagnosis where otherwise in the face of obstruction such procedures would be impossible.

If the patient is to be operated the tube can be left in place assuring the surgeon of completely collapsed gut at the time of operation rather than having to work in the midst of distended, edematous loops. The point of obstruction also can be determined exactly because the tip of the tube will be within 1-3 inches of that point. In some cases of large ventral hernias complete collapse of the bowel makes possible an operation which otherwise would be very difficult at best.

Post-operatively distension and all tension on the suture lines is prevented. Also with the tube in place liquid, salts, and food may be given early because the entire gastro-intestinal tract above the tip of the tube is available for digestion and absorption while the tube itself acts as an enterostomy preventing the fluid from collecting at the site of operation.

A very important item to be constantly considered while the tube is in place is the fluid and chemical balance of the body. Any case which has partial or complete obstruction for any length of time with resultant loss of fluids, salts, and food has a disturbed chemical balance. Also while the tube is in place it is draining out 2000 to 5000 cc. daily which contains serum protein, salts and fluids.

Abbott in a recent article suggested that the fluid aspirated through the

(Continued on Page 306)

October Meeting

The FOURTH Tuesday in the Month

October 22nd

AT THE YOUNGSTOWN CLUB

DR. EDGAR V. ALLEN

from

Mayo Clinic

Subject:

Peripheral Circulation

Allen, Edgar van Nuys, B.S., M.A., M.D., M.S. in Medicine, F.A.C.P., was born June 22, 1900, at Cozad, Nebraska; received the degrees of B.S. and of M.A. in 1923, and the degree of M.D. in 1925 from the University of Nebraska.

Dr. Allen entered The Mayo Foundation as a special student in medicine July 1, 1925, and became a Fellow in Medicine July 1, 1926. His services included general diagnosis, nine months; medical hospital, twenty-one months; pathologic anatomy, six months; neurology, six months; and medical research, three months. He was appointed first assistant in medicine April 1, 1927. He was on leave of absence from April 1, 1929, and studied in Munich and London for ten months. He returned as an associate in medicine at The Mayo Clinic, and instructor in medicine, of The Mayo Foundation, June 1, 1930.

In 1932, Dr. Allen received the degree of M. S. in Medicine from the University of Minnesota. He was appointed assistant professor of medicine, The Mayo Foundation in 1934, Associate Professor in 1937, and head of a section in medicine in 1935.

Dr. Allen's attainments in surgery have been recognized in his election as a fellow of the American College of Physicians of which he is governor for Minnesota. He is secretary of the Section on Pharmacology and Therapeutics of the A. M. A. He is a member of the American Society for Clinical Investigation, the Alumni Association of the Mayo Foundation, the Central Clinical Research Club (Past President), the Central Society for Clinical Research (Councilor), the Section for the Study of the Peripheral Circulation of the American Heart Association (Chairman in 1937), the Southern Minnesota Medical Association, and the Minnesota Society of Internal Medicine.

Not content with the lonely existence suggested by the above, Dr. Allen adds Alpha Omega Alpha, Sigma Xi, The Mayo Foundation Chapter (Vice President), and Phi Chi. He is a member of the Editorial Board of the American Heart Journal, and of the Committee on Cardio-Vascular Diseases of the National Research Council to help advise the Surgeons General of the Army and Navy.

●

Following the Scientific Address

DR. ROBT. T. ALLISON

Member of the State Committee on Medical Service Plans

will discuss

The Medical Service Enabling Act

The meeting will begin promptly at 8:30 P. M.

Annual Dinner-Dance

Saturday, October 26th

YOUNGSTOWN COUNTRY CLUB

•

IMPORTANT - - - RETURN AT ONCE

Enclosed with your invitation was a request for reservations to the Dinner Dance. If you have not returned it (with your check) do so at once.

Tickets $5.00.

Reservations close Wednesday, October 23rd.

Autumn Postgraduate Series

November 14th and 15th

•

DR. HENRY LE ROY BOCKUS

Prof. Gastro-Enterology
Jefferson Medical College
Philadelphia, Pa.

•

1. The Present Clinical Status of Chronic Gastritis—Wednesday, 11:00 A. M.
2. What Constitutes Adequate Therapy for Chronic Peptic Ulcer?—Wednesday, 4:00 P. M.
3. The Practical Application of Recent Advances in our Knowledge of Liver Functions—Wednesday, 8:30 P. M.
4. Diagnosis and Management of Chronic Ileitis and Ileocolitis —Thursday, 11:00 A. M.
5. The Diagnosis and Management of the "Irritable Colon" —Thursday, 4:00 P. M.

•

(Out-of-town Doctors invited. No fee)

The Use of Double Lumen Intestinal Tube in Small Intestinal Obstruction

(Continued from Page 303)

tube contains roughly the same concentration of sodium chloride as the blood plasma and that by estimating the total amount of drainage the amount of salt which needs to be supplied the body can be roughly estimated.

Other men use liter for liter of normal saline to material aspirated. When the tube has reached the lower ileum enough food can be given by mouth to keep up the plasma protein, before that transfusion may be necessary to supply the necessary proteins. The chemical balance is very essential and its restoration is one of the reasons why the mortality rate has been lowered in intestinal obstruction.

The use of the intestinal tube does not eliminate the use of the older methods of treating distension such as the use of hot compresses, pitressin, enemas and the rectal tube, oxygen inhalations and hypertonic saline solution. These are valuable procedures and are to be used as a supplement to intubation.

There are a number of cases of obstruction where intubation is contra-indicated. These are strangulated obstruction including internal hernia, volvulus and intussusception. In these cases intubation delays the operation and definitely increases the mortality.

Occlusion of the mesenteric artery and vein has a high mortality whether operation is delayed or not. Johnston and associates feel that with possibility of better vascularization in collapsed bowel intubation is indicated.

A certain number of complications follow the prolonged use of the tube. These include otitis media, sinusitis and rupture of esophogeal varices. The very annoying irritation in the nose and throat can be alleviated with oily nose drops and some of the anesthetics such as nupercaine and metycaine.

Results: In many cases intubation is only a temporary measure prior to surgery. In some, intubation is not successfully accomplished and some cases are not benefited even with the tube in place.

Abbott and Johnston in their original 16 cases had 3 failures to pass the tube, 9 of the 13 successful intubations had spontaneous return of function, the remaining 4 required operation.

The Presbyterian Hospital series give an interesting group of comparative mortality rates. In the 5 year period 1919-1924 prior to the use of the continuous suction the mortality rate for acute intestinal obstruction was 66%. For the 5 year period 1935-37 following Wangensteen's introduction of continuous suction the mortality rate fell to 20.7%. During the 18 months the Miller-Abbott tube had been in use the mortality rate for acute intestinal obstruction was 5.9%.

Johnston at City of Detroit Receiving had 64 cases of acute intestinal obstruction with a mortality rate of 9.5%.

There have been 18 cases admitted to both North and South Units since July 1, 1939, with diagnoses of acute intestinal obstruction. Eight of these had operations, 1 had continuous gastric suction, 2 used Miller-Abbott tube successfully, 1 intubation was unsuccessful, the remainder used other types of treatment. There were 3 deaths in the 18 cases.

Summary

1. Intubation requires considerable time and effort both in placing the tube and in its care. A certain number of intubations are not successful and in many it is only a temporary measure.

2. The blood chemical balance is essential and probably one of the main reasons why acute intestinal obstruction now has a lower mortality rate than formerly.

3. The older forms of treatment of acute intestinal obstruction are still valuable and must be used with intubation.

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3. Decompression of Small Bowel (R. J. Noer & C. G. Johnston), Am. J. Digest. Dis. 6:46-49, March, '39.
4. Intubation of human small intestine; treatment of obstruction and procedure for identifying lesion (W. O. Abbott), Arch. Int. Med. 63:453-468, March, '39.

Intracranial Hemorrhage

(Continued from Page 301)

is epidural or subdural. In the epidural type, the hemorrhage is between the dura and the inner table of the skull, having its origin from the anterior branch of the middle meningeal artery which courses across the great wing of the sphenoid bone. Thus, a hemorrhage of this type is arterial in origin.

Fracture of the skull is the rule, although not always present. The middle meningeal artery, as it grooves along the inner surface of the skull, is torn at the fracture line. The artery may be torn on the side opposite the injury by a mechanism called "contra-coup"—whereby the brain is actually thrown or slapped against the other side of the skull. After the middle meningeal artery is torn, a vicious circle occurs. Numerous tiny branches of the artery pass from the bone to the dura, and as the dura is progressively stripped from the bone by the hematoma, these branches are successively torn, thereby starting new bleeding points which add to the original hematoma.

In the subdural type where the hemorrhage is between the dura and the brain and is venous in origin, there may be an accompanying laceration of the cerebral cortex. There is, generally, no fracture and the venous outflow of blood is not as severe as the arterial. Seventy percent of these occur in the right temporal region—which is a "silent area." One-fourth per cent of them are bilateral, via "contra-coup."

The symptomatology is self explanatory when it is correlated with these pathological findings. In the epidural type, there is a history of head injury with unconsciousness or a dazed period lasting from a few seconds up to an hour or so. Then follows a recovery period—the lucid interval—in which the patient may walk or drive home and feel perfectly normal. ("I'm all right, let me go home.") This lasts for an hour or so up to eighteen or twenty-four hours. Then as the artery begins to build up a larger and larger hematoma, headache occurs, drowsiness, increasing stupor, and coma, with a rise in blood pressure, a slowing of the pulse, and stretorous respirations — all of these coming on fairly rapidly within 24 to 48 hours. The bleeding is over the temporal lobe and there first occurs a dilation of the pupil on the affected side with a loss of corneal reflex on the opposite side. Then as the hemorrhage spreads upward to the motor area, paralysis occurs or possibly convulsions, Jacksonian in type, of the opposite side of the body. These occur *first* in the face, then in the arms, and then in the legs. It is said that a paralysis or twitching in the legs or arms first, without the face, almost excludes the diagnosis of extra-dural hemorrhage. The signs are generally well localized focally in the face, arms, and legs, there being quite definite paralyses or twitchings. In this type there is the same history of a blow, with unconsciousness, but no lucid interval. Thus the onset of the stupor and coma are more rapid than in the epidural type because there really is no acutal lucid interval, the stupor and coma beginning soon after the injury. However, the course and progression of symptoms are more gradual, the changes in blood pressure, pulse and respiration are the same,

only slower in onset and not as marked because of two reasons: First, the bleeding is not as severe as in the epidural type; and second, the bleeding is not localized sufficiently to cause acute cerebral compression. The focal signs are quite vague and very hard to elicit. There may be only a slight weakness of the grip of one hand, or maybe one arm when lifted, flops down more flaccidly than the opposite one. There may be only an absent abdominal or cremasteric reflex on the contra-lateral side. Often when there is laceration of the brain substance, the patient lies characteristically curled up on his side with a rigid neck, probably due to the meningeal irritation of the free blood.

Now a word about the spinal tap —a mooted question. In the epidural type hemorrhage the fluid is under high pressure and clear unless there is associated subdural injury. In this type, it is especially dangerous because of the possibility of the release in pressure allowing the medulla to be jammed down into the foramen magnum. The removal of spinal fluid provides just that much more room for bleeding, and the bleeding arteries in this space are quick to take advantage of the let-down in the pressure tamponage. The hemorrhage, previously slowed up to some degree, begins anew, intracranial pressure increases, and coma deepens. In the subdural type the pressure is also increased, but the color of the fluid ranges from a yellowish pink to frank blood. It is sometimes held that the blood in the subdural hemorrhage could be drained by spinal tap but the amount that can be drained in this way is so small as to be inconsequential and, besides, the hemorrhage is usually clotted and partly encapsulated. The release in the tamponage only permits the brain and small veins in the pia-arachnoid space to ooze all the more.

The treatment in both epidural and subdural hemorrhage is subtemporal decompression. If there are localizing signs, the decompression is done on the side indicated. If no localizing signs are found, as is quite frequently the case, a right subtemporal decompression is performed. If no blood is found at this site, the operation is repeated on the left side; because, as stated before, seventy percent of all subdural hematomas not showing definite localizing signs are located in the right subtemporal region with forty percent of them bilateral.

Illustrative Case Reports

L. C. White, male, age 29.

Admitted 5:00 P. M., 1-28-40. Semi-stuporous and complaining of headache and backache.

H. P. I.: Received severe injury to head (a blow or fall?) on the 25th of January, approximately 72 hours previous, rendering him unconscious. He remained in this state of semi-stupor at an out-of-town hospital until he was transferred here.

Physical examination: T. P. R. 100-60-16. Bp. 150/85.

Well developed and nourished, breathing stertorously in a semi-stupor. Could be aroused by insistent and repeated questionings, but lapsed into coma when let alone. No incentinence.

Head: Laceration on vertex of skull 2", well scabbed over. Facial muscles lagging on left side.

Eyes: Eyeballs roving out pu[illegible] equal to light and accommodation

E. N. T.: No bloody discharges from ears, nose or pharynx.

Neck: Marked rigidity.

Thorax and Abd.: Neg.

Extremities: No evidence of fracture; all extremities able to be moved by patient. Muscle flaccidity and grip weaker in the left leg and hand.

Reflexes: Biceps, patellars, abdominal, cremasterics, absent bilaterally. Kernig's and Brudzinskis positive.

Impression: Cerebral concussion

with subdural hematoma, probably in the right temporal region.

X-ray: Neg. for fracture of skull.

Laboratory: W.B.C. 14,000, 83% polys.

Spinal Fluid: Bloody, increased pressure. Culture neg. No organisms in smear.

Course

(1) 500 cc. 50% glucose intravenously.

(2) Rt. subtemporal decompression. There was found a mushy lacerated area of brain tissue under the squamous portion of the temporal one. This tissue was removed by suction; bleeding controlled with silver clip. Closed.

Postoperatively: 50 cc. 50% glucose intravenously, every 8 hours, as needed for headache. Spinal tap with lowering of pressure to 100 mm. H_2O each 24 hours.

Pressure ranged from 330 mm. to 100 on the 8th day, which was the last tap. Convalescence uneventful otherwise. Home 10th day. Back to work in the mills 3 months later.

Summary of therapy:

(1) Right subtemporal decompression.

(2) Spinal tap each 24 hours for increased blood pressure and headache, as needed.

(3) 50cc. of 50% glucose intravenously every 8 hours.

Similar to the history of this case is one I remember seeing in another city. This patient was a man who had fallen down stairs and bumped his head. The police found him unconscious and rushed him to the hospital. By the time they had reached the emergency room, the patient was perfectly normal in action and apparent condition. So he went home. We got him approximately 24 hours later in another hospital. He was in coma and almost moribund. I don't remember the exact physical findings but the neurosurgeon made a diagnosis of epidural hematoma, which was confirmed at surgery. A large clot the size of a baseball was found. The patient died a few hours later.

These are examples of the right way and the wrong way to treat head injuries. All patients with a history of head injury with concomitant stunning or unconsciousness, should be hospitalized for at least 24 hours. The fact that a patient is drunk is no assurance that he might not have actual brain damage, too.

As for prognosis, it can be summed up in the statement of Dandy: Given a 100 cases of head injury; 80% will recover with only symptomatic treatment (bed rest, and isolation); 10% will die no matter what the treatment may be; and the last 10% will live or die depending upon whether or not they receive prompt and proper treatment.

SECRETARY'S REPORT

The regular Council meeting was held at the office of the Secretary, September 9th, 1940.

The following application for membership in the Society has been approved.

For Active Membership:
Dr. S. H. Davidow

Unless objection in writing to this applicant is filed with the Secretary within 15 days, he becomes a member of the Society.

On Tuesday, September the 17th, the regular monthly meeting was held at the Youngstown Club, the guest speaker being Dr. Harold N. Cole, Professor of Dermatology and Syphilology, Western Reserve School of Medicine, Cleveland, Ohio. Dr. Cole's well presented talk was on "Malignancies," a timely and important subject.

The regular October meeting will be held the FOURTH Tuesday, instead of the usual third, or October 22nd. Dr. Edgar Allen from the Mayo Clinic will speak on Peripheral Circulation.

DR. JOHN NOLL, Secretary.

THE MEDICAL CRIER

A Page of Sidelights, News and Views in the Medical Field

● For a perfect one week's vacation trip, the Crier recommends a 1500 mile circle which will take you through Pennsylvania, West Virginia, Maryland, Virginia, North Carolina, Tennessee, Kentucky and Ohio. This is the best time of the year to make it for the leaves are turning brilliant red and gold and the mountain scenery is breath taking.

Starting not too early in the morning, you can easily reach Cresson for lunch at Lee Hoffman's. Then down through Bedford in the Allegheny Mountains where you get a glimpse of the new Dream Highway which is now open for use. The drive from Breezewood down through Hancock to Winchester is beautiful. At Fort Royal, Virginia, you must stop to buy apple candy before starting on the Skyline Drive. One-third of the way down the Skyline is Panorama, here your supper will be served in a big beamed room before a log fire which feels mighty good on an evening in the mountains. A little piece onward is Skyland where you can get a cottage of anywhere from two to eight rooms, one to three bathrooms and a roaring fire in the large living room. In the evening you can dance in the recreation hall or lounge in the library or look down over the valley at the twinkling lights of Luray.

In the morning the boy comes to get you up and build your fire. You walk out on your porch and there is the beautiful blue Shenandoah valley spread below your feet, squared with fields and dotted with toy barns and doll houses. If you care to stay a day or two there are horses to ride and hikes to take, but a week is short and you will leave this place vowing to return soon and spend more time.

Following on down the Skyline Drive you stop at the many parking overlooks to view the ever-changing scene of rugged mountains on the east and the winding Shenandoah river on the west. Coming to the end at last, down the winding mountain road you go, past Virginia plantations to Charlottesville wondering all the way about how hot the day is getting now that you have left the mountains. At Charlottesville you visit the University of Virginia with its famous serpentine wall, and Monticello of course. After a lunch of English muffins and Virginia ham at Michie's Tavern you will feel sorry that we Damyankees ever fought with those nice people.

The ride down through Virginia to North Carolina takes you past the pine trees and unpainted shacks of the poorer South where natives drowse in the sun with feet on the porch rail and black children shout at you as you pass. But at Durham, forty miles below the state line there is evidence of wealth and culture. The Gothic spires of Duke University rising from among its wide landscaped gardens is a sight worth the trip. At the Washington Duke hotel there is good living with the best of southern spoon bread, cornsticks and yams. Twenty miles to the east lies Wake Forest, soon to enlarge its medical school into a full-fledged four-year course. At Raleigh are the ancient capitol buildings and North Carolina State University. Eight miles west of Durham at Chapel Hill lies the University of North Carolina with its beautiful buildings, its shaded walks and graceful bell tower.

The ride westward across North Carolina is mostly on smooth concrete roads lined with fields of cotton and tobacco. Nearing Asheville you will hurry to get over the stretch of mountain driving before dark, through Beaucatcher tunnel and up to the Grove Park Inn for supper. You will want to stay a while in this

great stone hotel with its massive fireplaces and friendly atmosphere. You will be glad you brought your clubs, for spread in the valley below are the well kept fairways and greens of the Asheville Country Club where you are welcome to try a round of golf. Horses are ready in the hotel stables and the trails wind up and up to the top of Sunset Mountain. Many side trips to Lake Lure and to Chimney Top can be taken from Asheville, but the Smokies are the big attraction, so off you start for Cherokee Indian Reservation where the best road through the National Park begins.

If you are expecting another Skyline Drive you will be greatly surprised. No view over peaceful valley and winding river, but wooded mountains, quiet and somber. An excellent road winds its way up to New Found Gap where President Roosevelt delivered his dedication address last Labor Day. From there a new road takes you to Forney Ridge which is tops at 6,400 feet unless you want to get out and walk up to Clingman's Dome. Going down the Tennessee side is the same winding road which gets so involved that it finally runs under itself and then straightens out to take you into Gatlinburg. There are plenty of horses at Gatlinburg, mostly of the easy going plantation type, and plenty of park to ride in. If your time is limited you can at least take the "lower loop ride" which starts at the Mountain View Inn, goes up one side of the mountain and down the other. All the way you ride besides or splash across the clearest, coolest mountain stream you ever saw. Near the foot of the mountain the cabin dwellers dip the water into great blackened pots and heat it over wood fires to do their washing and cooking beside the stream, but higher up there are no cabins and it splashes its solitary way in silvery cascades over boulders washed round and white with years of its scouring. Wild life holds sway here and if you are lucky you might see a shiny black bear come down to his favorite pool for a drink. If you can stay, there are longer rides to take and the hotel will send a boy with lunch to meet you anywhere in the park. No, you must not miss the riding at Gatlinburg.

At Knoxville you leave U. S. 25 to take the by-pass over Norris Dam which isn't so much unless you like to look at concrete dams. With a nod to the Senator you pass on and up into Kentucky. The southern coal region of Kentucky around Harbin is poor country at best. Berea has a lovely old school and you can stop at the College Shop and buy little beaten biscuits and products of the mountain hand looms. You will be glad to get on up to Lexington where the American saddle horse is king. Here you can visit Spindletop and Dixiana farms and wish you had a million and could stay here the rest of your life. But you don't have the million and you are beginning to worry about the patients back home so on you go to Cincinnati, that fine old city, Ohio's gateway to the South.

From Cincinnati northward you get an ever increasing feeling of being back home. After all, Ohio is a beautiful state with fertile land and prosperous looking farms. The last of the trip is always the best part for it brings you back to familiar scenes where you are no longer just a tourist, but one of the folks—a responsible person in the community, contributing to its welfare.

—J. L. F.

THE OLD FASHIONED PICNIC

Once more as hearty a bunch of clam-clawing, corn-crunching, chicken-chewing, base-stealers, as ever shot a skeet, rolled a bone, hurled a horse shoe, twirled a twister, or caught an incipient "Corrigan" eddied together for fun, at "Bert-old-Boy's" place, Wednesday P. M., September 11th.

Everything was a prize. Every event a special favor. The mere chance to lose at some of the G's of C, was a privilege. Even Bob Poling learned that powder and a pretty gun are not the sole defense, whether in peace or in war. Bill Bunn warned him: "You gotta have morale. Hold 'er steady, that's it," says Bill. Bill can't shoot either, against those St. E's, but Bob's new at that gag. Just wait-the writer, that's me, use to have a roommate, a wale of a fellow, but who literally had enuresis at the mere sound of a little thunder. But he's today the champeen of all the shoot-guys of the Southern Medical Association. So, cheer up, my chieftain. (Trouble is, nobody down South could hit a rabbit 10 feet away—until tomorrow mawnin'.)

Nobody reported on the baseball score — but, admitting its heftiness detracts not from the game's niftiness. Times were when Patrick and Nesbit seemed to be confused as to the respective merits of the *status quo* and forward or backward progression *statim* or *post*. The noise of the rooters, largely advice, sometimes jeers, but generally cheers—added to the evident pleasure. Fisher's mercurial reaction was evident, rising and falling with the temper of the grand-"Standers."

This horse-shoe pitching business has got to be a menace. We oldsters used to go out to the picnics and we were the only ones who had ever heard of such a game. We'd just put those smarty interns to sleep. No more! They're on. They ring 'em, we roll 'em—horseshoes is still the subject. Something needs to be done about it. . . Maybe we can have these kids drafted—that's it, have'em drafted, then we old guys can stay back home, safe with the congressmen.

Other excellencies we old ones have, however. We maybe know what things to consider when the old skin splotches up, and Walker advises, when confronted with opisthotic distress, or something, not to wash too vigorously back of the ears. Every little bit helps, as the old seaside lady said, and a fair exchange is no robbery. No matter, we're all together now for the hard pull, and possibly for the big push!

"Bigger and better Old Fashioned Picnics"—if possible, Jimmy. Everybody thanks you—and "so long" until the big dance, October 26th, 1940.

NEWS AND VIEWS

Dr. John E. L. Keyes participated in a Symposium on Orthopedics before the Section on Eye, Ear, Nose & Throat of the American Congress of Physical Therapy at Cleveland on September 4, 1940.

Dr. John Keyes and Dr. William Hatcher have been appointed associate examiners by the American Board of Ophthalmology for the examination to be held at Cleveland in October.

Dr. Louis S. Deitchman was on the program of the American Association of History of Medicine at Cleveland, October 7th, reading a paper on Early Medical Printing.

Dr. Louis S. Deitchman attended the meeting of the American Academy of Ophthalmology and Otolaryngology, October 7-8-9 and 10, at Cleveland.

Dr. Evans, Odom and Wenaas presented a symposium on the "Eye"

at the September meeting of the Staff of St. Elizabeth's Hospital. The papers were on "Glaucoma," "Cataract," and "Examination of the Eye from the Standpoint of the General Practitioner."

St. Elizabeth's Hospital again reports the largest number of admittances in its history. During the month of August, 1104 patients were admitted to the hospital and in the obstetrical department, one hundred and forty-two babies were born. The surgical department reports five hundred and fifty operations.

Dr. J. Heberding attended the recent meeting of the American Roentgen Ray Society in Boston.

Dr. and Mrs. Morris Neidus are the proud parents of a baby girl born October 1st, St. Elizabeth's Hospital.

Dr. and Mrs. Saul Tamarkin announce the birth of a daughter Bryna Doris on September 5th.

Dr. and Mrs. W. B. McElroy spent some time vacationing at Virginia Beach and New York City.

Dr. and Mrs. W. Stanley Curtis attended the World's Fair in New York, from there motoring through the New England States.

Dr. and Mrs. J. N. McCann spent a few days in Washington, D. C. Dr. McCann attended the annual meeting of the Society for the Study of Neoplastic Diseases.

Dr. and Mrs. Jas. L. Fisher and Dr. and Mrs. D. M. Rothrock spent an enjoyable vacation motoring through the South, making a tour of Great Smoky Mountain National Park.

Dr. L. W. Weller attended the 51st Annual Meeting of the American Association of Railway Surgeons at the Palmer House week of September 15th.

Dr. and Mrs. Stanley W. Myers enjoyed a motor trip to Denver, Colorado.

Dr. and Mrs. A. E. Brant are home after spending three weeks at Honey Harbor, Georgian Bay, Canada.

Richards-Brandmiller Wedding

Miss Jean Elizabeth Richards and Dr. Barclay Miller Brandmiller were wedded at the United Presbyterian Church of Struthers, Thursday afternoon, September 19th.

Dr. Brandmiller and his bride left for the East and will be home after October 17th, 4039 Market St.

The bride, a graduate of Ohio University, has been teaching for two years at Hartford, Ohio.

Dr. Brandmiller, a graduate of Wittenberg College and Jefferson Medical College, is a prominent young physician.

Hospital Exhibit

The Staff Committee of the Youngstown Hospital Association, in charge of the exhibits for the public, announce that the exhibit will be held November 11th, 12th and 13th, 1940. These dates fall on Monday, Tuesday and Wednesday.

The exhibits will be shown in the basement rooms of the Tod Nurses' Home.

Medical Techs. Meet, Plan

The Youngstown Society of Medical Technicians met September 5 at the North Side Unit of the Youngstown Hospital.

Plans for the coming year were discussed. Suggestion was made for a period of each meeting to be used in discussion of current laboratory methods. The group also decided to send a member to the Ohio State Medical Association's convention, which will be held in Cleveland early in June, 1941. The Technicians' next meeting will be held at the North Side Unit of the Youngstown Hospital, October 3rd. Dr. Margarite Stemmerman will speak on "Health Conditions in India."

NURSES NOTES

Sr. Germaine, Supt. St. Elizabeth's Hospital, and Sr. Margaret Louise, Clinical Supervisor, attended the meeting of the American Hospital Association in Boston, September 16-20.

Attending the State meeting of the National League of Nursing Education in Columbus, Friday, October 11, were Miss Dorothy Windley, Sr. Theophane, Sr. Margaret Louise, Miss Helen Rein and Miss Jennie Baker.

O. S. N. A. District No. 3 met October 9 at the Y. M. C. A. auditorium. Guest speaker was Professor Frank D. Slutz of Dayton, Ohio, who spoke on "Personality as Applied to Nursing." Hostess was Warren City Hospital Alumnae Association.

St. Elizabeth's Hospital School of Nursing will hold graduation exercises for the Senior class at the Stambaugh Auditorium October 15, at 8 p. m. Diplomas will be presented to 20 young women. Speaker will be the Right Rev. Monsignor Howard W. Smith, S.T.E.D., J.C.D.

Youngstown Hospital staff nurses recently organized the Graduate Nurses' Association of Youngstown Hospital. Officers elected for the year were: C. Marie Fawcett, president; Ethel Baksa, secretary, and Florence Miller, treasurer. The next meeting will be at the South Side Unit, November 6, at 8:30 p. m., Alma Lawson in charge of arrangements.

Miss Jennie Zhuck has been appointed assistant night supervisor at the South Side Unit, Youngstown Hospital.

Miss Sue Thomas who has been associated with the x-ray department of the South Side Hospital, will leave shortly for Ann Arbor, Michigan, to work on the coöperative nursing program while attending the University of Michigan.

Dorothy Seise, graduate of St. Elizabeth's Hospital School, class '29, was married August 20 to Howard E. McFetrich. Mrs. McFetrich has been employed as a general staff nurse.

Ethel Billock, graduate of St. Elizabeth's Hospital School, class '38, was married on August 23 to Vincent Collet.

Submitted by Ruth E. Neilson.

FINDINGS FROM THE FIELD

Male Sex Hormone Gives Relief for Premenstrual Discomfort

(Medical Annals of the District of Columbia)

Prolonged and intense discomfort preceding menstruation followed by profuse and prolonged bleeding was relieved by the administration by mouth of the male sex hormone, testosterone propionate, Robert B. Greenblatt, M. D., Augusta, Ga., reports in *The Journal of the American Medical Association* for July 13, 1940.

He cites the cases of two patients in whom the hormone relieved premenstrual headaches, nervousness, abdominal pain and bloating, general discomfort, lumpy and painful breasts, fatigue and crying spells. The bleeding cycles also became more regular and the amount and length of the flow were decreased, in one instance from twelve to four days.

Dr. Greenblatt contends that the relief obtained by his patients warrants further trial of this method of treatment not only for the harrassing and distressing advance symptoms but also because with the onset of menstruation the tense, nerve-wrought and weary patient is further weakened by her excessive loss of blood.

The Surgeon

(From Detroit Medical News)

Equanimity, judgment, precision, knowledge, straight thinking and human understanding—these to our way of thinking are the qualities of one of man's best friends—the Surgeon.

We are never without wonder at the drama of the operating room—there, skilled hands, courage and hope work side by side with Life and Death. Nearly always the battle is won—more times than not. There are many today who owe their lives and their happiness to the hands and the heart of the surgeon.

We have seen the stress and strain of the surgical drama when seconds counted and we have realized what it must take to carry on. We have known so many who had that splendid courage.

They are the most self effacing lot of fellows, these surgeons—they speak only of their cases, never of themselves. They are an unselfish group these modern cavaliers whose sword is the scalpel and whose battle cry is—Let us give life.

We never knew a surgeon, who, in his heart, was not humble—we never knew one who was not human.

B.McD.

(Now maybe you "cut-ups" know what "wows" you are!)

The American Association of the History of Medicine

(Bulletin, Med. Society County of Erie, Buffalo Academy)

The American Association of the History of Medicine which holds its annual meeting each Spring at Atlantic City, has decided to institute regional meetings. The first of these will be held under the sponsorship of the Medical History division of the Ohio State Archeological and Historical Society, on October 7th, 1940, in the Cleveland Medical Library Auditorium, Cleveland, Ohio.

A cordial invitation is extended to all those interested in the history of medicine to attend these sessions and, of course, this includes the ladies.

Any Physician May Exhibit "When Bobby Goes to School" to the Public

Under the rules laid down by the American Academy of Pediatrics, their new educational-to-the-public film "When Bobby Goes to School" may be exhibited to the public by any licensed physician in the United States.

All that is required is that he obtain the endorsement by any officer of his county medical society. Endorsement blanks for this purpose may be obtained on application to the distributor, Mead Johnson & Company, Evansville, Indiana.

Such endorsement, however, is not required for showings by licensed physicians to medical groups for the purpose of familiarizing them with the message of the film.

"When Bobby Goes to School" is a 16-mm. sound film, free from advertising, dealing with the health appraisal of the school child, and may be borrowed without charge or obligation on application to the distributor, Mead Johnson & Company, Evansville, Indiana.

POSITION WANTED—By practical nurse with 1½ years of nurses training, also experience in handling telephones, meeting public, and typing. Phone 20053 or address 1934 E. Midlothian Blvd.

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BRIEF HISTORICAL NOTES ON MEAD'S CEREAL AND PABLUM

HAND in hand with pediatric progress, the introduction of Mead's Cereal in 1930 marked a new concept in the function of cereals in the child's dietary. For 150 years before that, since the days of "pap" and "panada," there had been no noteworthy improvement in the nutritive quality of cereals for infant feeding. Cereals were fed principally for their carbohydrate content.

The formula of Mead's Cereal was designed to supplement the baby's diet in minerals and vitamins, especially iron and B_1. How well it has succeeded in these functions may be seen from two examples:

(1) As little as one-sixth ounce of Mead's Cereal supplies over half of the iron and more than one-fifth of the vitamin B_1 minimum requirements of the 3-months-old bottle-fed baby. (2) One-half ounce of Mead's Cereal furnishes all of the iron and two-thirds of the vitamin B_1 minimum requirements of the 6-months-old breast-fed baby.

That the medical profession has recognized the importance of this contribution is indicated by the fact that cereal is now included in the baby's diet as early as the third or fourth month instead of at the sixth to twelfth month as was the custom only a decade or two ago.

In 1933 Mead Johnson & Company went a step further, improving the Mead's Cereal mixture by a special process of cooking which rendered it easily tolerated by the infant and at the same time did away with the need for prolonged cereal cooking in the home. The result is Pablum, an original product which offers all of the nutritional qualities of Mead's Cereal, plus the convenience of thorough scientific cooking.

During the last ten years, these products have been used in a great deal of clinical investigation on various aspects of nutrition, which have been reported in the scientific literature.

Many physicians recognize the pioneer efforts on the part of Mead Johnson & Company by specifying Mead's Cereal and PABLUM.

Pablum is a palatable mixed cereal food, vitamin and mineral enriched, composed of wheatmeal (farina), oatmeal, cornmeal, wheat embryo, beef bone, brewers' yeast, alfalfa leaf, sodium chloride, and reduced iron.